Written Testimony

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The National Rural Health Association (NRHA) is pleased to provide the United States House Committee on Veterans' Affairs with a statement for the record on Evaluating Federal and Community Efforts to Eliminate Veteran Homelessness.

NRHA is a national nonprofit membership organization with a diverse constituency of 21,000 individuals and organizations who share a common interest in rural health. NRHA's mission is to improve the health of rural Americans and provide leadership on rural health issues through advocacy, communications, education, and research.

The members of NRHA have maintained a special concern for the health care needs of rural veterans for many years. NRHA was one of the first non-veteran service organizations to develop a policy statement on rural veterans, and strongly advocates expanding access to care for rural veterans, including improving the ability of providers to treat rural veterans, enhancing care delivery mechanisms, expanding access, and promoting provider understanding of the special needs of rural veterans. NRHA is pleased to have been one of the first national organizations to support the creation of the VHA Office of Rural Health and enjoys an ongoing and highly productive relationship with this office within VA.

While only 20% of Americans live in rural areas,[1] a disproportionate number of those serving in the military come from rural communities. Currently, there are approximately 22 million living veterans in the United States, with about 5.3 million (24%)[2] living in rural areas. Rural Americans also comprise 36% of the total enrolled veteran population in the U.S. Department of Veterans Affairs (VA) system, and 15% of

[1] U.S. Census, 2010. Washington: Government Printing Office, 2010.
[2] Veterans Health Administration Office of Rural Health (May 2014). Fact Sheet: Information about the Office of Rural health and Rural Veterans.

veterans live with at least one service-connected disability.[3] The most common of these disabilities are tinnitus and hearing loss, post-traumatic stress disorder (PTSD), diabetes mellitus, musculoskeletal issues, and traumatic arthritis.[4] Rural veterans are also aging significantly – the median age is 62, compared with 44 in urban areas.[5] While rural veterans generally mirror their rural population cohort, many times they experience layered complexities that their urban counterparts may not experience, such as a lower median income and fewer housing options.

Unfortunately, it is not true that all veterans have local access to comprehensive care. Combat veterans in need of specialized physical and behavioral care returning to their rural homes will likely find that access to care is extremely limited. Because of the disproportionate number of rural Americans serving in the military, there is a greater need for veteran-centered care in rural areas, making it difficult for rural veterans to receive timely, appropriate services.

When rural veterans are unable to get adequate care, their challenges can compound. Lingering effects from untreated PTSD and other psychological injuries can often contribute to veteran homelessness. Among Iraq and Afghanistan veterans who screen positive for PTSD or depression, 19% report possible TBI, 45% have mental illness, and 70% suffer from substance abuse issues.[6] The lack of access to trained professionals in rural areas may also be a contributing factor to the observed increase in homelessness in these areas. Support networks are key in the reintegration process, and homeless veterans are more socially isolated than the nonveteran homeless population.

[3] Veterans Health Administration Office of Rural Health (April 2013). Fact Sheet: Information about the Office of Rural health and Rural Veterans.
[4] Veterans Benefit Administration (June 2013). Annual Benefits Report Fiscal Year 2012.
[5] Minnesota Population Center. Integrated Public Use Microdata Series: Version 3.0. Minneapolis: University of Minnesota, 2010.
[6] Henry, M. Cortes, Al, and Morris, S. The 2013 Annual Homelessness Assessment Report (AHAR) to Congress. US Department of Housing and Urban Development.

Many rural veterans face significant geographical barriers to obtaining their care. Driving long distances is a challenge for veterans with poor health or limited financial resources, veterans needing specialized or routine care, or those needing emergency care. In addition to geographical challenges, veterans in rural areas may face further barriers to accessing care such as unemployment, lack of health insurance, and limited finances. Also, the social determinants that can result in overall poorer health status, are prevalent in many rural areas across the country. The health disparities emerging from these issues are further compounded for those rural veterans who are additionally burdened with combat-related stress, chronic disease, mental health challenges, homelessness, and/or substance abuse. In their lifetimes, an estimated 50% of rural homeless veterans will experience mental illness and 70% will have a substance use disorder.[7]

These barriers to care in rural America contribute to the fact that veterans make up a greater portion of the homeless population in rural areas.[8] Rural homelessness comprises 7% of total homelessness,[9] and these populations are more invisible to the general public and current efforts to identify rural homeless veterans do not adequately address the extent of the geography that must be covered and the high-level resources needed to accurately count them.

Rural homelessness presents a unique and difficult problem. Rural areas harbor fewer employment opportunities, lower wages, and longer unemployment periods, and also generally lack emergency or temporary homeless shelters and targeted service

[7] DeLong, Katie. "Wisconsin receives $1.2 million federal grant to help homeless veterans." November 11, 2014. Fox News.
[8] U.S. Department of Housing and Urban Development. 2012. The 2011 Annual Homeless Assessment Report to Congress.
[9] Jackson, A. and Shannon L. Examining Social Support in a Rural Homeless Population. Journal of Rural Social Sciences, 29(1), 2014, 48-74.

providers.[10] Again, to collect accurate data on the rural homeless is a more nuanced prospect, and the situation does not often fit federal or other official definitions.[11] In 2009, nearly eight million rural residents lived below the poverty line[12] – in addition to facing a lack of affordable housing, the rural homeless must also contend with substandard housing, rent increases, lack of public transportation, limited subsidized housing programs, and long distances between affordable housing and job opportunities.[13] All these factors contribute to veteran homelessness.

While homelessness has historically been significantly more prevalent in the urban veteran population, the issue is an increasing concern in suburban and rural areas. Though 21% of Americans live in rural places, 25% of all veterans live in these communities.[14] The year-over-year increase for 2009-2010 in the number of sheltered homeless veterans, as reported by the VA in 2012, was approximately 18.5% for suburban and rural areas, compared with only 1.3% for urban areas.[15] Veterans in general are overrepresented among the national homeless population, and rural veterans face unique barriers. Rural veterans are more likely to be homeless for longer and have serious medical issues, and face limited opportunities for adequate shelter and care.

Homelessness often takes unique forms in rural areas, and rural veterans face different challenges than their urban counterparts – geographic isolation being a key component of these difficulties. Though the 2014 Point-in-Time (PIT) Count, declared

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[10] Ibid.
[11] Jackson, A. and Shannon L. Examining Social Support in a Rural Homeless Population. Journal of Rural Social Sciences, 29(1), 2014, 48-74.
[12] National Law Center on Homelessness and Poverty, 2011.
[13] Jackson, A. and Shannon L. Examining Social Support in a Rural Homeless Population. Journal of Rural Social Sciences, 29(1), 2014, 48-74.
[14] Oberdorfer, Eric. "In Rural America, Veterans Continue to Fight for Housing Aid." November 12, 2013. Rooflines.
[15] National Center for Veterans Analysis and Statistics (September 2012). Profile of sheltered homeless veterans for fiscal years 2009-2010.

that the number of homeless veterans dropped to 57,849, it is unclear how much progress has been made against veteran homelessness in rural America.[16]

Inadequate housing and lack of affordability are also significant challenges to rural veterans. About 38% of veterans in rural areas are cost-burdened, and 23% live in inadequate housing. Veterans in nonmetropolitan areas are also more likely to live in substandard housing than veterans in general, and overcrowding can be a proxy to homelessness.[17] In addition, rural veterans are on average 18 years older than urban veterans (70% of rural veterans are 55 or older[18]), and thus face expenses in home modernization, which may force them into poorer living conditions.[19] 83.3% of rural veterans own their homes, and aging makes it more difficult to sustain independent living in their homes – grants for home modifications and caregiving subsidies may not be readily available in their areas. Younger returning veterans also struggle to find and sustain affordable housing in rural areas, which have less rental options. Not all these veterans qualify for the VA loan guaranty program for home buyers – in 2012, 16.8% of VA loan applications were not granted for rural America.[20] Supportive housing vouchers, a small proportion of which are allocated to VA Medical Centers (VAMCs), come with restrictions on where veterans can find housing – "within a reasonable distance from a VA facility" – such that appropriate shelter may be more difficult to locate.[21]

Though new programs, VA and otherwise, have provided innovative solutions to homelessness, not all of them reach rural places as well as urban centers. The U.S.

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[16] Shane III, Leo. "Homeless vets in rural areas lack options, advocates say." April 11, 2014. Army Times.
[17] Housing Assistance Council (2014). From Service to Shelter: Housing Veterans in Rural America.
[18] Oberdorfer, Eric. From Service to Shelter: Housing Veterans in Rural America. Housing Assistance Council. September 11, 2014.
[19] Shane III, Leo. "Homeless vets in rural areas lack options, advocates say." April 11, 2014. Army Times.
[20] Oberdorfer, Eric. "In Rural America, Veterans Continue to Fight for Housing Aid." November 12, 2013. Rooflines.
[21] Ibid.

Department of Housing and Urban Development, for example, has issued about 60,000 VA Supportive Housing vouchers over the past five years, but only three percent of these vouchers were distributed to VAMCs in rural areas.[22] NRHA strongly supports specific solutions to meet the challenges of providing quality care to our rural veterans and preventing homelessness. NRHA believes that improving access to care must be a priority for both the Administration and Congress, and submits the following recommendations:

1. Expanded Non-VA Care Program

In order to enable rural veterans to obtain care more easily, the VA should develop and implement policies that encourage use of the Non-VA Care Program in rural areas in a consistent manner across all Veterans Integrated Service Networks (VISNs) and that reflect a "best interest of the veteran" standard for utilization determinations.

In some rural areas local providers are inconsistently included in VHA networks, meaning that many veterans do not have access to these routine specialty services unless they are willing and able to travel significant distance to a central VA facility. Given the most prevalent conditions for which veterans seek treatment, the lack of availability of specialty providers in these areas is particularly concerning. In response to Veteran wait times and access issues created by long distances to VA facilities, the VA created the "Veterans Choice Card" as part of the "Veterans Access, Choice and Accountability Act of 2014. These cards were sent to eligible Veterans this past November and as more rural Veterans are enrolled and receive the Veteran Choice Cards for coverage by non-VHA providers, more efforts are needed to educate non-VHA providers about this who is eligible for this coverage and the requirements for provider participation. Community

[22] Ibid.

based education efforts in rural areas are needed to increase the awareness of both rural Veterans and non-VHA providers to the benefits of this coverage.[23]

Additionally, the increasing number of female veterans is creating new demand for women's health services, including basic obstetric and gynecologic services. Between 1992 and 2011, the percentage of rural women veterans more than doubled, rising from 3% to 7%.[24] The general critical shortage of obstetric and gynecological providers for all women in rural areas combine with the fact that VA-sponsored Community Based Outpatient Clinics (CBOCs) are not always staffed to provide obstetric and gynecological services causes female veterans to often travel significant distances to VA Medical Centers (VAMCs) for women's health services. In addition, female veterans are often at higher risk of homelessness than nonveteran females and male veterans, and are more highly concentrated in rural regions.[25] The Non-VA Care Program's network of fee-based specialty providers should be evaluated and expanded to ensure alignment with the most prevalent outpatient specialty needs of rural veterans.

VA should standardize and streamline policies regarding use of non-VA providers to better facilitate provider participation in the Non-VA Care Program and to expedite access for veterans to locally provided health care services, particularly specialty services.

VA should expand training programs for non-VA rural providers on evidence-based military, deployment, and post-deployment health and mental health diagnoses and treatment.

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[23] Philpot, T. "How 'Choice Card' and $15B will help veterans get care." Stars and Stripes. July 31, 2014.
[24] U.S. Department of Agriculture, Economic Research Service. Rural Veterans at a glance. Economic Brief 25.
[25] U.S. Department of Housing and Urban Development. 2012. The 2011 Annual Homeless Assessment Report to Congress.

2. Expanded Training and Education for TRICARE

Creating the best health care system for rural veterans requires that both patients and providers are aware and informed of the options available in the system. A key barrier to care is the lack of provider awareness and acceptance of TRICARE benefits. An April 2013 report found that 1 in 3 beneficiaries had difficulty finding a civilian provider who would accept TRICARE, and that only 39% of these providers would accept TRICARE patients.[26] Therefore, the U.S. Department of Defense (DoD) and VA should also develop a TRICARE health care provider education and awareness program to inform providers about the program and how to participate. Rural health providers should be particularly targeted for this provider education and awareness program.

Through its Office of Academic Affiliations, VA should increase its role in the training of undergraduate and postgraduate health professionals' education in evidence-based diagnosis and treatment of military-related health and mental health conditions and treatments across the trainee populations.

In addition, VA should develop a benefit education outreach program that provides clear information for patients and providers on what services, especially emergency services, are covered by VHA. Materials need to be readily accessible, easy to understand, and structured to encourage health and mental health-seeking behavior rather than deter seeking of care.

3. Mental Health Care

DoD and VA should develop a strategy specifically focused to materially increase the percentage of mental health providers willing to participate in the TRICARE

[26] U.S. Government Accountability Office. TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries. GAO-13-364.

program. Because of the link between mental health and homelessness, these initiatives are especially important.

Access to mental health specialists is even more limited for rural Americans and warrants specific attention. Rural areas in general suffer from a shortage of mental health specialists and face significant difficulties in recruiting and retaining qualified personnel to meet population needs.[27] Inadequate participation of available providers in VHA networks and a decreasing number of civilian providers who participate in the military's TRICARE system compound these shortages.

VHA has been increasingly using telemental health services to provide specialty mental health services in underserved areas. Telemental health services involve the use of communication technologies, particularly videoconferencing technology, to deliver various mental health services including diagnostic assessments, psychotherapy, and medication management. Advances in telemedicine capabilities holds potential to facilitate earlier identification and care of geographically isolated veterans affected by TBI and potentially reduce negative outcomes, including rates of suicide and homelessness.[28]

VA should continue to invest in research and application of telemedicine technologies to advance care, particularly mental health and brain injury care, for rural veterans. VA should also establish and report on quantitative and qualitative metrics that evaluate improvement in rural veteran health care access and health outcomes generated by Office of Rural Health (ORH) strategic plan initiatives. The approach to any mental

[27] Jameson JP, Blank MB. The role of clinical psychology in rural mental health services: defining problems and developing solutions. *Clin Psychol.* 2007;14(3):283-298.
[28] Cote MJ, Siddharta SS, Vogel WB, Cowper DC. A missed integer programming model to locate traumatic brain injury treatment units in the Department of Veterans Affairs: a case study. *Health Care Manag Sci.* 2007;10:253-267.

health outreach program should recognize the cultural stigma associated with mental health care in rural communities, along with the role that rural and military values play in veterans' desire or lack thereof to seek certain types of care. This approach should also recognize the intrinsic support role of the clergy, peer veterans, and family in rural communities and incorporate these groups in this outreach. The VHA Office of Rural Health's Rural Veterans Outreach Tool Kit is an excellent example of outreach strategies that recognize rural culture and rural veteran care-seeking behaviors and should be more widely used in VHA outreach programs and services in rural areas.

4. Funding VHA's Office of Rural Health

Congress should affirm its commitment to rural veterans by funding ORH at requested levels for FY2015 and FY 2016, demonstration projects related to increasing use of telemedicine and related remote care delivery systems, expanding the CBOC network, and aligning service offerings with the needs of rural veterans. Research and reports on rural veteran experiences also provide deeper insight into population health and barriers to care, as care issues are likely magnified in rural settings. Continued funding and interest in ORH ensures that resources are directed to areas where they can most benefit rural veterans. ORH should be funded and encouraged to work with VHA Homeless Programs, U.S. Department of Housing and Urban Development (HUD), U.S. Interagency Council on Homelessness (USICH), Housing Assistance Council (HAC), and other national stakeholders on pilot programs to specifically develop a Point In Time (PIT) Count or other appropriate methodology in targeted rural communities that will accurately reflect the picture of rural veteran homelessness. This type of work and interaction across federal agencies could lead to a broader and clearer understanding of

the issues and needs of rural homeless veterans and the rural homeless population in general.

5. Chronic Homeless Classification

HUD should continue efforts to implement policies to expand the classification of "chronic homeless" to maximize the number of rural homeless veterans eligible for homeless services within HUD, VA, and other federal, state, and local programs.

Conclusion

Health care for rural veterans continues to be most affected by issues of access. Barriers are most commonly related to geographic distance, availability of specialty and primary care providers, and health benefit considerations. There is also a concerning lack of understanding by patients and providers regarding VA benefits (i.e., what is covered and where), and there is an equally concerning lack of awareness in the provider community of the TRICARE system. These barriers can lead to veterans forgoing care entirely because of difficulty accessing VA facilities. Rural veteran homelessness, while a multifaceted matter, can be attributed to the lack of access to health care, as well as PTSD.

Providing health care in rural communities requires unique solutions, and we must all be mindful of long-term needs of our servicemen and women. The wounded veterans who return to their rural communities today will not need care for just the next few fiscal years – it is estimated that caring for Iraq and Afghanistan veterans alone could cost between $600 billion to $1 trillion over the next 40 years.[29]

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Committee on Veterans' Affairs. These programs are critical to

[29] Blimes LJ. Current and Projected Future Costs of Caring for Veterans of the Iraq and Afghanistan Wars (2011). Harvard University.

the rural health delivery system and for veterans to maintain access to high quality care in rural communities. We greatly appreciate the support of the Committee and look forward to working with Members of the Committee to continue making these important investments in the health of our rural veterans.